



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXOMA MEDICAL CENTER
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name

Farmington Casualty Co

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-0867-01

MFDR Date Received

November 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is \$2,954.66, minus their payment of \$2,082.57 there is still an outstanding balance of \$872.09."

Amount in Dispute: \$872.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the reimbursement methodology, and stands by the original reimbursement determination."

Response Submitted by: Travelers Companies Inc

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2010	Outpatient Hospital Services	\$872.09	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 27, 2011

- T182 97 – PYMT ADJUSTED BECAUSE THE BENEFIT FOR THIS SVC IS INCL IN THE PYMT/ALLOW FOR ANOTHER SVC/PROC THAT HAS ALREADY BEEN ADJUDICATED. PYMT INCLUDED IN APC RATE PER TX HOSP MEDICARE METHODOLOGY PER RULE 134.403(D).
- P10A W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. BASED ON ADDITIONAL

INFORMATION RECEIVED AND APPROVAL FROM ADJUSTER, AN ADJUSTMENT IS BEING MADE TO THE TOTAL REIMBURSEMENT OF THE ORIGINAL INVOICE.

Explanation of benefits dated October 27, 2011

Z10F 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY. AFTER CAREFULLY REVIEWING THE RESUBMITTED INVOICE, ADDITIONAL REIMBURSEMENT IS NOT JUSTIFIED.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 72100 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.94. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$25.76. The non-labor related portion is 40% of the APC rate or \$17.96. The sum of the labor and non-labor related amounts is \$43.72. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$43.72. This amount multiplied by 200% yields a MAR of \$87.44.
 - Procedure code 70450 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8005. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
 - Procedure code 70486 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8005. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item

in proportion to other separately paid services on the claim. The payment for composite services is calculated below.

- Procedure code 72125 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8005. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
 - Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$223.17. This amount multiplied by 60% yields an unadjusted labor-related amount of \$133.90. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$128.02. The non-labor related portion is 40% of the APC rate or \$89.27. The sum of the labor and non-labor related amounts is \$217.29. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$217.29. This amount multiplied by 200% yields a MAR of \$434.58.
 - Procedure codes 70450, 70486, and 72125 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8005, for computed tomography (CT) services without contrast. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8005, which, per OPPS Addendum A, has a payment rate of \$419.45. This amount multiplied by 60% yields an unadjusted labor-related amount of \$251.67. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$240.62. The non-labor related portion is 40% of the APC rate or \$167.78. The sum of the labor and non-labor related amounts is \$408.40. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$408.40. This amount multiplied by 200% yields a MAR of \$816.80.
3. The total allowable reimbursement for the services in dispute is \$1,338.82. This amount less the amount previously paid by the insurance carrier of \$2,082.57 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 17, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.